

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033943

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8237

FILED AUG 22 1963

1. PLACE OF DEATH  
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN

St. Louis

Length of stay in 1b

9 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE

Mo.

b. COUNTY

St. Louis

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (if NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

DePaul Hospital

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

5113 Aubert Ave.

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

THOMAS

First

J.

Last

MORAN

4. DATE OF DEATH

Month

Day

Year

Aug.

11

1963

5. SEX

male

6. COLOR OR RACE

white

7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

10/10/1883

9. AGE (last birthday)

79

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

police officer

10b. KIND OF BUSINESS OR INDUSTRY

law enforcement

11. BIRTHPLACE (City and state or country)

St. Louis

Mo.

U.S.A.

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

Frank Moran

13b. MOTHER'S MAIDEN NAME

Mary Kelly

14. NAME OF HUSBAND OR WIFE

Eunice Moran

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Eunice Moran 5113 Aubert Ave.

18. CAUSE OF DEATH (Enter only one cause per line for)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Brain tumor

INTERVAL BETWEEN ONSET AND DEATH

2-3 months

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

237X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Death occurred at

6-1-63 to 8-11-63 and last saw her alive on 8-10-63

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial

23b. DATE

8/14/1963

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis

Mo.

24. FUNERAL DIRECTOR

ADDRESS

Bachbels Mortuary 5967 W. Florissant

25. DATE RECD. BY LOCAL REG.

AUG 13 1963

26. REGISTRAR'S SIGNATURE

Paul Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

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# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
 or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
 working under my personal supervision.

Student \_\_\_\_\_  
 Signature of Student Embalmer

Signed Walter J. Buckholz

Licensed Embalmer No. 4557

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
 If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
 If this body is not embalmed, fact should be so stated above.

Funeral Home 201 W. Florissant  
 St. Louis 8  
 St. Louis 8